Correspondence

Medicine in the United States

SIR,—Being a very young doctor, it is with some diffidence that I criticize our old-established customs and institutions, but the letter of Dr. S. L. Simpson (June 28, p. 949) shows up in sharp contrast to many of the criticisms I have heard from my friends and seniors about medicine in the U.S.A.

I spent 2½ years at medical school in Boston, with a three-month break to visit Johns Hopkins, and feel justified in making a few comments on the contrast between these schools and our own London and university teaching systems. Without doubt the most inspiring teaching that I have ever had was at Harvard Medical School; and yet, taken as individual teachers, some of those from whom I have been privileged to learn in this country are without equal anywhere. It was not the system of teaching at Harvard that impressed me, with its frequent examinations throughout the course, which came first as a rude shock and then as a rather unpleasant stimulant to one used to the more haphazard and individualistic Cambridge ideas, but the atmosphere. It was the continual thirst after new knowledge of our teachers and the way in which they accepted all criticism and questioning, whether from students or colleagues, as genuine attempts at furthering knowledge rather than sly traps by rivals. Everyone was kept very much alive, and a spirit of friendship and co-operation pervaded.

Dr. Simpson mentions the "collaborative sessions" at the Peter Bent Brigham Hospital. One of these was a weekly event called the "Clinico-Pathological Conference" and locally known as the C.P.C. (The Massachusetts General Hospital also had one weekly.) These were so good and so helpful to us as students that I feel justified in describing them in the hopes that a similar session may be introduced into some of our hospitals. They were organized by the pathology department, which would collect the notes from an old case that had been treated in the hospital and extract them on to a mimeographed sheet containing: (1) the patient's complaint as described by himself; (2) the past history of the patient up to admission; (3) the clinical findings as recorded on entry and the relevant laboratory findings; (4) a very brief outline of the patient's course in hospital, finishing with either "an operation was performed" or "the patient died." These sheets were distributed to all those attending, and a guest speaker, usually from another hospital but certainly a doctor who had no previous knowledge of the case, was invited to discuss the diagnosis and therapy. *X*-ray films were provided, and he could, if he wished, ask for and expect advice on any points outside his own specialty. The case was always chosen taking into consideration the speaker's special subjects, so that we could listen to an expert analysing a case in his own field. The speaker would go through the case point by point giving his differential diagnoses and stating how he thought the recorded course of the patient fitted these or ruled them out. At the end, if the case was surgical, the surgeon who operated would tell of his findings, or, if medical, the pathologist would give the necropsy findings, illustrated with photographs and sections on the screen. The speaker was often wrong in his diagnosis, because the cases were difficult and had often caught out the staff of the hospital, but no one was offended and everyone felt that they had gained by the experience.

Latterly the Brigham went further, and final-year students, usually about eight at a time, were occasionally briefed a week beforehand for the discussion, being given the case history to think about. This gave them a chance to look up the relevant literature. (I believe that most of the speakers were given some warning.) On the appointed day the students took the front seats and one was drawn by lot to speak. This victim then had to discuss the case before his teachers. These conferences were voluntary but were very well attended, being one of the most popular features at the medical school.

There is just one other point that I should like to make emphasizing a statement in Dr. Simpson's letter, because I hear so much about the American laboratory diagnostician. I had more teaching in psychosomatic medicine at Harvard than I have seen or heard of in England. Also my instructor in medicine once said to me, "If the laboratory data do not agree with your clinical findings, have the tests repeated. If they still do not agree, neglect them." The laboratory work at Harvard is not a short cut to diagnosis but an adjunct to research and sometimes a gauge of the patient's progress under treatment. My criticism of medicine in Boston is that it aims too much at research, if that is possible.—I am, etc.,

Ely, Cambs. N. K. CONNOLLY.

World Medical Association

SIR,—In the Supplementary Report of Council (*Supplement*, June 21) I was very glad to see that the Council had prepared a statement to be submitted to the General Assembly of the World Medical Association in September, 1947. As I have been appointed by the Medical Women's International Association in my capacity as their honorary treasurer to act as an observer at the meeting of the Assembly, I should like to take the opportunity of saying how strongly I agree with the Council's view that the medical profession as a whole have a grave responsibility towards their fellow men, not only as doctors but as leaders of public opinion in the field of moral and ethical values.

During the terrible years of occupation by a brutal enemy the large majority of doctors of most of the occupied countries maintained their moral integrity, their unswerving loyalty to their patients, and their spiritual and professional freedom, even at the risk of torture and death. They thereby set a great example and vindicated the honour of their profession.

Now that the war is over we are faced with a curious and dangerous shift of values. On the one hand men and women in so many countries are refusing to submit in any particular to the power of individual employers, while on the other hand they appear willing and even eager to denude themselves of every vestige of personal and political freedom and to surrender all their liberties to the State. This must lead insidiously but surely, as it did in Germany, to a growing disregard for the value of the life and human rights of the individual. As the Council so truly says in its statement, "The doctors who took part in these deeds (i.e., medical war crimes) did not become criminals in a moment. Their amoral methods were the result of training and conditioning to regard science as an instrument in the hands of the State to be applied in any way desired by its rulers." The Council might have added that the doctors were trained and conditioned to regard human beings, including their patients, as mere robots or sub-human statistics entirely unimportant in themselves, and therefore subordinate to the will and interests of the State and its rulers.

This horrible distortion of values is one which doctors have an especial duty and, if we will only use it, a considerable measure of power to resist and overthrow wherever we find it developing in our midst. The principles which are included in Appendix 2 to form a part of a Charter of Medicine are fundamental, but I would suggest that they should be extended to include a statement that the medical profession affirm their belief in the sanctity of the rights of the individual as a human being, and pledge themselves to safeguard these rights in all their dealings both with their patients and in relation to any function which they may be called upon to exercise in their capacity as medical men and women. Let us never forget that "the price of freedom is eternal vigilance."—I am, etc.,

London, W.1. DORIS M. ODLUM.

Symmetrical Gangrene in the African

SIR,—The condition described by Dr. Michael Gelfand (June 14, p. 847) appears to be of sufficient rarity to justify my quoting an almost identical case which fulfils his six diagnostic criteria. The patient was seen in the province of Sidamo, Ethiopia, in 1945.

CASE REPORT

An adult male Sidamo aged between 30 and 35 was brought by his friends from a village some long distance away. He gave a history of being in good health and symptomless until some 3–4 months previously, when quite suddenly he had an attack of "rheumatism" in his legs and feet, which became swollen and painful. A little later the toes and soles of his feet appeared "as though dead." There was no history of recent attacks of malaria, typhus, or other disease. He had had syphilis at least ten years before, for which he had not received any treatment. His general nutritional state was good, and his diet appeared satisfactory.

On examination a condition rather similar to that shown in Gelfand's first photograph was seen, though more advanced. Both feet were blackened, dry, and wizened, particularly on the underside, and flies were crawling in and out of the various cavities in the mummified gangrenous area. The line of demarcation was not as pronounced as is shown in Gelfand's second photograph, but ran from about 1½ in. (3.81 cm.) proximal to the base of the toes to just below the level of the malleoli. No pulsation could be felt in the dorsalis pedis or in the femoral artery of either side. There was